

PROFESSIONAL MEDICAL CONDUCT IN NEW YORK STATE*

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ON behalf of the New York Academy of Medicine, I am pleased and honored to welcome you to this conference to discuss the program of the Board for Professional Medical Conduct. The Academy has played a major role in the recruitment of members for the Board for Professional Medical Conduct and those of us at the Academy who have served on the Board along with other Board members are acutely aware of the problems involved in the prompt and judicious treatment of this difficult and most important issue. A small group of us at the Academy, including the late Dr. James E. McCormack, former director of the Academy, Dr. David McNutt, present director, Drs. Stanley Gitlow, Frank Iaquina, Cyril Jones, Dr. Marvin Lieberman, executive secretary of the Committee on Medicine in Society, and I have met periodically over the past five years to consider ways to improve the system. Discussions have also been held during the past year with staff members of the Board from the Department of Health, including Miss Kathleen Tanner, director, Mrs. Chris Stern-Hyman, counsel and Dr. Maynard C. Guest, executive secretary, without whose contributions and cooperation this meeting could not have occurred.

The Board for Professional Medical Conduct was organized by state law under the aegis of the Department of Health in 1975 to investigate complaints concerning professional misconduct of physicians, to be followed, if deemed proper, by administrative hearings and subsequent recommendations for appropriate disciplinary action. The impetus for this law was dissatisfaction with the then existing mechanism of disposition of these problems. Despite changes that have occurred in the law and additions to supporting staff, the process remains slow, often frustrating, to the Board and staff, and increasingly difficult for the present limited staff. The new legislation which man-

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dates the reporting of physicians' misconduct by hospital professionals and administrators may well swamp the system as currently funded.

We physicians take pride in the dignity and integrity of our profession and its contribution to the public. Hence, it is our intent that those who are accused of misconduct be treated appropriately, promptly and fairly. The members of our Board, physicians and laymen alike, are able and distinguished in their respective activities away from the Board and are dedicated to its purpose. We want to avoid, at all costs, the substitution of a simplistic solution such as might be offered by a "commissioner for discipline."

FUNCTIONING OF THE SYSTEM

As the system operates it has several problems:

Composition of the panels. Currently there are four physicians and one lay person. Can we get along with three or even two physicians and one lay person? If so, can we permit a substitute for one panel member in the event this individual becomes ill or dies? This would speed the process by making it easier to constitute hearing panels.

Conduct of hearings. How can the often dilatory tactics of the respondents' lawyers be controlled? Cannot the administrative law judge and the chairman play more assertive roles in this phase of the process? In setting dates for hearings, can greater strictness for all be observed? In obtaining delays for scheduled hearings, can the only excuses for nonappearance by the respondent physician and/or his lawyer be limited to illness and mandated court appearance elsewhere? Letters of excuse from a presiding judge or treating physician should be required. In the event that such conditions are not met, cannot the panel proceed without the presence of the respondent and/or his lawyer? We are concerned in our hearings about Court of Appeals reversals. Yet only two have been obtained and these were remanded to the panels. At present hearings cost about \$2,000 each, exclusive of costs for staff personnel and travel costs for Board members. In some instances as many as 30 panel hearings have been held over a period of several years. It should be observed that "plea bargaining" does not exist in this process and very few respondents surrender their licenses. This accounts for the relatively large number of cases referred to panels.

Role of the Commissioner of Health. As the review step after the hearing panel, is review of the records by the Commissioner as rapid as possible? Could more legal support staff help?

Role of Regents. Following the Commissioner's review, is that of the Regents as quick as possible? Could it be expedited by enlarging their support staff? At present the final disposition of the Regents may be published. Would not a greater deterrence be a more detailed and substantive statement by the Regents?

Probation. In 12 of 44 recent cases, periods of probation were imposed yet the Board has no machinery for surveillance of these activities. It is a function of the Department of Education, and up to now follow-up information to the Department of Health and the Board has not been readily forthcoming. If this function is to remain in the Department of Education, can the reporting machinery be improved? The Board could profit from such information.

Office of the Board for Professional Conduct. Could the process be speeded up by enlarging the investigating and secretarial staffs? At present the case load is 1,200, with only 20 investigators statewide and 11 actively prosecuting lawyers.

Funding. How much money is needed to provide the best system? Could this not come from increased medical license registration fees with such monies earmarked for this purpose? It would be a sad irony if the functioning of the Board were to become irrelevant because of inadequate funding. We have seen this happen in other regulatory governmental agencies.

Summary of Discussion*

The discussion that followed Dr. Post's speech ranged over a variety of topics. Several speakers argued that the medical profession has an extraordinary capacity to affect other human beings. Therefore, in restructuring a system of medical discipline, we face a dilemma that performance will be measured against very high standards and it is inevitable that on occasion we shall fall short. We must establish the highest standards of performance and the best oversight system possible. We are dealing with a system of monitoring one aspect of quality of care and professional medical conduct, part of an overall process. Among long-term factors that may lead to improvement are more active roles for consumers and better informed patients. The enormous growth of information retrieval and analytic capability in medicine will surely have positive results. We need to identify physicians who are incompetent and negligent and to reach physicians who are neither mem-

*Marvin Lieberman, J.D., Ph.D., Executive Secretary, Committee on Medicine in Society, The New York Academy of Medicine.

bers of hospital staffs nor of medical societies and who are not keeping up with new knowledge. It was also suggested that the tendency for physicians to work in organized groups would also improve surveillance of quality. On the other hand, speakers recognized that a formal process of professional medical discipline would always be required along with adequate funding and support.

The remainder of the discussion may be conveniently summarized under the following headings:

FUNDING:

Several speakers indicated that the current system is clearly underfunded. On at least one occasion the legislature approved additional funds for staff for the Board on its own initiative, and on another occasion delays occurred in the executive branch in filling positions in the Department of Health for the Board of Professional Medical Conduct. Some legislative leaders believe that since the governor has discretion to utilize or not to utilize funds appropriated by the legislature to the executive branch, no one can force the governor to fill positions in the state government. It was suggested that the membership size of the Board for Professional Medical Conduct be doubled. Additional physicians are needed to analyze complaints and to assist attorneys to prepare statements of charges. Additional attorneys and investigators are also required to prosecute cases.

THE ROLE OF THE BOARD OF REGENTS:

It was pointed out that a total shift from the Board of Regents to the Department of Health would reduce the steps in the disciplinary process but it is unlikely that the role of the Board of Regents would change. One participant suggested that there is no possibility that the legislature will favorably entertain a request to give total disciplinary jurisdiction over the medical profession to the Health Department to the exclusion of the Board of Regents. Yet the process of decision-making in the Board of Regents could be speeded up. The necessity for a two-person Review Committee was questioned. Could not the Board of Regents designate one person as part of a Hearing Panel? Other participants questioned why two state entities should determine state health policy.

DELAY:

Substantial attention was paid to how delays in the process of hearings could be reduced. It was pointed out that, out of 45 current hearings underway, 10 have required as many as 23 to 36 days of actual hearing and none of these cases is completed. It is difficult for busy active practitioners to schedule consecutive hearings for an entire week. Delays could be reduced in the following ways: Continue the practice of refusing to postpone sessions at the behest of attorneys without good reason and proof; categorize cases so that nonmedical issues could either be heard by an administrative law judge or, where specific crimes have been committed such as drug abuse, these matters could go directly before the Board of Regents; increase the legal staff of the Commissioner of Health to facilitate the Commissioner's participation. It was suggested that motivation for delay on the part of the respondent could be reduced if interim revocation of licensure by the Commissioner should take place pending final action by the Board of Regents.

SIZE OF PANELS:

Differences of opinion existed about maintaining the current size of the panels, now composed of four physicians and one lay person. It was noted that a key member of the legislature has argued that to have a proper level of interaction and range of judgement in dealing with a complex case, the current size of the panel was essential. A spokesman for the State Medical Society indicated that it would not oppose having three physicians and two laymen to develop a larger pool for hearing panel participants.

SUMMARY SUSPENSIONS:

Under new legislation signed by the governor, the period of summary suspension* has been extended from 60 to 90 days and even further. An average of one day of hearing each week and five days of hearing during the first 40 days of the summary suspension order would be required. It was suggested that to facilitate the summary suspension process, a group of physicians who would commit themselves to continuous hearings should be developed. Perhaps this list could be developed from physicians in salaried practice.

*"[W]here a physician is deemed to be causing, engaging in or maintaining a condition or activity which in the Commissioner's opinion constitutes an imminent danger to the health of the people." Sec. 230, Sub. 12., N.Y. State Public Health Law."

SURVEILLANCE:

Questions were raised about the adequacy of supervision of adherence to penalties for medical misconduct, including suspension, revocation and probation. It was pointed out by a representative of the Education Department that undercover visits are made by staff of the Education Department to see that physicians honor probation. Representatives of the Education Department expressed willingness to improve communication with the Department of Health on the process of surveillance. A suggestion was made that surveillance could be carried out under contract by professional organizations.

THE DISCIPLINE PROCESS FOR CALIFORNIA:

For comparison with the approach to regulation of professional medical conduct in New York State, a brief summary of the medical discipline process in California was presented. The Department of Consumer Affairs in the State of California embraces 34 independent regulating boards, including a Division which regulated allied health professions, a Division of Licensing and a Division of Medical Quality which has seven members, four of whom are physicians. The Division of Medical Quality is responsible for medical discipline functions. A \$200 biannual licensure fee is dedicated for all licensing purposes, including examination and medical discipline. The budget in 1983 was approximately \$11 million, of which \$7.5 million went to enforcement. During recent years an average of 3,000 complaints were heard with hearings on approximately 250. Reporting to the Division of Medical Quality are 14 District Medical Quality Review Committees, each serving several counties in the state. It is a policy of the Division that cases will be heard on consecutive days. A Medical Quality Review Committee may decide to hear a case but if the Medical Quality Review Committee feels that they lack expertise, cases will be heard by a single administrative law judge. Approximately 70% of the cases are heard by administrative law judges.

A decision by the local District Medical Quality Committee dismissing a case, or suspending a license for 30 days or less, or limiting a physician's practice for less than a year is final and no appeal is allowed in such cases. For other cases heard by the Administrative Law Judge and more serious cases heard by the District Quality Review Committees after a decision at the lower level, the matter goes to the full seven member Division of Quality Assurance. A judgment by the Division is final except for issues of law, which may be appealed to the courts. Some 70% of the cases are stipulated.

The California Administrative Procedures Act governs the conduct of hearings. Lawyers from the California Attorney General's office prosecute the cases.

In conclusion, except for agreement on the need for more money to help the system to function, there were wide differences of opinion on many issues among the participants. There was agreement however, that a positive aspect of the conference was an opportunity to air differences in perceptions about the program. The valuable role of the New York Academy of Medicine in serving as a catalyst in encouraging so many interesting suggestions for improvement in the system was also recognized. Hope was expressed that the Academy would review the proceedings of the conference and develop its own findings and recommendations for public consideration.